VISION EXAMINATION FORM FOR WEARERS OF BIOPTIC TELESCOPIC LENS

MED 40 (Rev. 07/02)

PLEASE PRINT OR TYPE.

APPLICANT'S FULL NAME *Last* *First* *Middle*	SOCIAL SECURITY NUMBER
RESIDENCE/HOME ADDRESS ☐ CHECK HERE IF THIS IS A NEW ADDRESS.	CITY
If you change either your residence/home address or mailing address to a non-Virginia address, your driver's license and/or photo identification (ID) card may be canceled.	
MAILING ADDRESS	

CITY	STATE	ZIP CODE	DATE OF BIRTH

HISTORY

Include changes in vision measurements over the past year. Note any conditions that may affect the eyes and require vision re-examination.

Is the patient's condition stable? ☐ Yes ☐ No ☐ Uncertain	Recommended vision re-examination every _____

Explain:

ACUITY

VISUAL FIELD

	RIGHT	LEFT	BOTH	
Without correction				Conduct test (test object must be at least 3 mm) and record reading below.
With correction (through carrier lens)				
Through telescopic lens				

TELESCOPIC LENS

MAKE OF TELESCOPIC LENS	POWER OF LENS	DATE APPLICANT RECEIVED LENS

DIAGNOSIS

PROGNOSIS

NAME OF EYE CARE PRACTITIONER *(PLEASE PRINT)*	TELEPHONE NUMBER ( )	FAX NUMBER ( )

BUSINESS ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE OF EYE CARE PRACTITIONER	PROFESSIONAL DESIGNATION	EXAMINATION DATE